

**UnitedHealthcare Insurance Company of the River Valley  
Attachment D - Schedule of Benefits**

*Please refer to your Provider Directory for listings of Participating Physicians, Hospitals, and other Providers.*

<b>Deductibles and Maximums</b>	<b>Participating Provider In-Network</b>	<b>Non-Participating Provider (1) Out-of-Network</b>
<b>Deductible (calendar year) / (Contract Period)</b>		
Individual	\$4,000	\$7,500
Family	\$8,000	\$15,000
All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount. The In-Network Deductible and Out-of-Network Deductible are separate.		
<b>Maximum Out-of-Pocket Expense (calendar year)/(Contract Period) (includes Copayments, Coinsurance, and Deductibles)</b>		
Individual	\$6,600	\$15,000
Family	\$13,200	\$30,000
All individual Maximum Out-of-Pocket amounts will count toward the family Maximum Out-of-Pocket Expense, but an individual will not have to pay more than the individual Maximum Out-of-Pocket Expense. The In-Network Maximum Out-of-Pocket Expense and Out-of-Network Maximum Out-of-Pocket Expense are separate. Pharmacy cost sharing applies towards the Maximum Out-of-Pocket.		
<b>4<sup>th</sup> Quarter Deductible Carryover</b>	Not Applicable	Not Applicable

<b>Benefits for Covered Services</b>	<b>Participating Provider In-Network</b>	<b>Non-Participating Provider (1) Out-of-Network</b>
<b>Preventive Care Services</b> <i>("Preventive Care" refers to examinations and services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.)</i>		
Physical Exams/Well-Child Care	Covered at 100%	60% of Allowed Charge after Deductible
Immunizations	Covered at 100%	100% of Allowed Charge. Deductible does not apply.
Laboratory and X-ray	Covered at 100%	60% of Allowed Charge after Deductible
<b>Physician Office Services</b>		
Office Visits	100% after you pay a Copayment of \$30 PCP/\$60 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Office Surgery	100% after you pay a Copayment of \$30 PCP/\$60 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Testing	100% after you pay a Copayment of \$30 PCP/\$60 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Allergy Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Other Injections	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
Maternity Physician Services	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Newborn Services</b>		
Inpatient	<i>See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	
Outpatient	<i>See "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	

<b>Benefits for Covered Services</b>	<b>Participating Provider In-Network</b>	<b>Non-Participating Provider (1) Out-of-Network</b>
<b>Physician Services at a Facility other than the Office</b>		
Home Visits	100% after you pay a Copayment of \$30 PCP/\$60 Specialist per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
Inpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility Visits	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Surgery (1)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Surgery (1)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Emergency Services (1)</b> <i>(Follow-up care obtained in the emergency room is not covered.)</i>		
Emergency Room Physician	100% of Allowed Charge. Deductible does not apply.	Same as In Network
Emergency Room	100% after you pay a Copayment of \$250 per visit for initial care only of a Medical Emergency. Deductible does not apply. Emergency Room Copayment waived if admitted.  <i>Physician's services or other services separately charged may require a separate Copayment and/or Coinsurance in addition to any applicable Deductible, beyond the emergency room facility charge.</i>	Same as In Network
<b>Urgent Care Facility</b>		
	100% after you pay a Copayment of \$75 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Ambulance Services</b>		
	80% of Allowed Charge after Deductible. <b>Non-emergency transports must be approved in advance by UnitedHealthcare.</b>	80% of Allowed Charge after Deductible. <b>Non-emergency transports must be approved in advance by UnitedHealthcare.</b>
<b>Laboratory, X-ray and Other Diagnostic Testing</b>		
Outpatient	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	100% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Major Diagnostics (MRI, MRA, CAT and PET Scans)</b>		
	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<i>Note X-ray and laboratory services separately charged by an independent laboratory may require separate Coinsurance and/or Deductible, beyond the physician's office Copayment, Coinsurance and/or Deductible.</i>		
<b>Chemotherapy, Radiation Therapy, Renal Dialysis Services</b>		
Hospital (Outpatient)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office	80% of Allowed Charge. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Facility Services</b>		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Skilled Nursing Facility (2) <i>(Member is limited to 100 days per calendar year)(Contract Period). The 100 In-Network and Out-of-Network days are combined.)</i>	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Medical Equipment</b> <i>(Diabetic supplies do not count toward the Durable Medical Equipment benefit maximum.)</i>		

<b>Benefits for Covered Services</b>	<b>Participating Provider In-Network</b>	<b>Non-Participating Provider (1) Out-of-Network</b>
Durable Medical Equipment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Prosthetic Devices (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Hearing Aid Devices (2) <i>(No Copayment or Deductible will be applicable to Hearing Aid Coverage.)</i>	80% of Allowed Charge. Deductible does not apply.	Not covered
<b>Outpatient Rehabilitative Therapy and Habilitative Services</b>		
<i>Outpatient Rehabilitative Therapy includes physical, speech, and occupational therapy and cardiac (Phase I and II) and pulmonary rehabilitation.</i>		
<i>(Member is limited to 60 outpatient treatment visits per (calendar year)/(Contract Period). The In-Network and Out-of-Network visits are combined.)</i>	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Habilitative Services – Outpatient Therapy</b> <i>30 outpatient visits for any combination of physical therapy, occupational therapy and speech therapy for Habilitative Services.</i> <i>Any combination of physical therapy, occupational therapy and speech therapy, is limited to 180 hours per year for Habilitative, medically necessary developmental Services.</i>	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Home Health Services (2)</b>		
	80% of Allowed Charge after Deductible	Not Covered
<b>Hospice Services (2)</b>		
Respite Care (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Organ and Tissue Transplants (2)</b>		
	<i>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories</i>	Not covered
<b>Cornea Transplants</b>		
	<i>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories</i>	
<b>Clinical Trials</b>		
	<i>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories</i>	
<b>Temporomandibular Joint Services (2)</b>		
	<i>Covered as any other medical condition. See “Physician Office Services,” “Physician Services at a Facility other than the Office,” “Facility Services,” or other applicable categories.</i>	
<b>Mental Health Services</b>		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of \$60 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Substance Abuse Services</b>		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible

<b>Benefits for Covered Services</b>	<b>Participating Provider In-Network</b>	<b>Non-Participating Provider (1) Out-of-Network</b>
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of \$60 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>Neurobiological Disorders - Autism Spectrum Disorder Services</b>		
Inpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Inpatient Physician Visits (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Facility (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Outpatient Physician Services (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Partial Hospitalization/Intensive Outpatient Treatment (2)	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
Office Visits	100% after you pay a Copayment of \$60 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<b>In vitro fertilization (2)</b>	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Medical Foods (2)</b>	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Musculoskeletal Disorders of the Face, Neck or Head (2)</b>	<i>Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	
<b>Orthotic Devices and Services (2)</b>	80% of Allowed Charge after Deductible	60% of Allowed Charge after Deductible
<b>Craniofacial Anomaly Services (2)</b>	<i>Covered as any other medical condition. See "Physician Office Services," "Physician Services at a Facility other than the Office," "Facility Services," or other applicable categories.</i>	
<b>Virtual Visits</b>	100% after you pay a Copayment of \$30 per visit. Deductible does not apply.	60% of Allowed Charge after Deductible
<p>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</p>		

#### Coverage Limitations:

- (1) For services from Non-Participating Providers, the Allowed Charge is defined in Article 1 of the Certificate of Coverage. The Member is responsible for paying any amounts exceeding the Allowed Charge for services received from Non-Participating Providers. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.

The Allowed Charge for Covered Services rendered by a Non-Participating Provider in a Medical Emergency will be determined as described in Section 1.1.2 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Provider's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense.**

For both Inpatient Surgery and Outpatient Surgery, Covered Services provided by facility based Non-Participating Physicians in a Participating Hospital or facility will be paid at the In-Network benefit level, however the Allowed Charge will be determined as described in Section 1.1.3 of the Certificate of Coverage. **As a result, the Member will be responsible for the difference between the Non-Participating Physician's Billed Charges and the Allowed Charge. Such excess amounts will not count toward the Deductible or Maximum Out-of-Pocket Expense. In order to obtain the highest level of benefits, the Member should confirm whether a Physician is a Participating Physician prior to obtaining Covered Services.**

- (2) Services require Preauthorization. When a Member uses Participating Providers, the Participating Provider is responsible for obtaining Preauthorization. When a Member uses Non-Participating Providers, the Member is responsible for obtaining Preauthorization from UnitedHealthcare (or for mental health and substance abuse services, from UnitedHealthcare's mental health and/or substance abuse treatment program provider). If the Member fails to obtain Preauthorization for Covered Services from Non-Participating Providers, the Member will pay a Penalty of an additional 10 percentage points in his or her Out-of-Network Coinsurance. The Penalty amount paid by the Member will not exceed \$1,000, and it will not count toward the Deductible or Maximum Out-of-Pocket Expense.

This document is provided as a brief summary and is not intended to be a complete description of the benefit plan. After you become covered, you will be issued a Certificate of Coverage (COC) describing your coverage in greater detail. The COC will govern the exact terms, conditions, and scope of coverage. In the event of a conflict between this Schedule of Benefits and the COC, the language of the COC controls.